



Utilization Review:

Understanding the Problem, Being Part of the Solution

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Utilization Review in Tennessee

16th Annual Tennessee Workers' Compensation Educational Conference

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Associate National Medical Director



What is Utilization Review?

- ❖ A disciplined approach to treatment requests that helps an injured worker receive the right care at the right time
- ❖ Utilization Review (UR) compares requests for medical services against evidence-based guidelines and literature to determine if treatment is medically necessary and appropriate for the covered injury

What are the goals of UR?

- ❖ Improves resource utilization and application by optimizing medical or surgical treatment timing, frequency and duration
- ❖ Facilitates an injured workers receiving medical care which promotes a timely, functional outcome and improves return to work ability
- ❖ Controls over utilization of medical resources by applying the best available evidence on treatment outcomes

What Is Evidence Based Medicine?

“...the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

...means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

Sackett D.L et al. BMJ '96 312:71-80

Elizabeth Genovese MD/ACOEM 2004

Why Evidence-Based Medicine?

- “This degree of variance amounts to a roll of the dice in making health care decisions” Donald Berwick MD, CEO, Institute for Healthcare Improvement
- “Random treatment strategies create random outcomes. ... This...does not inspire confidence in medical care” John Wennberg MD, Dartmouth School of Medicine
- “Evidence-based summaries and consumer information are critical because there are no acceptable alternatives” Andrew Oxman, Norwegian Cochrane Center

Elizabeth Genovese MD/ACOEM 2004

What are Evidence-Based Practice Guidelines?

❖ Two components:

– Systematic reviews

- Evidence search
- Study analysis, grading, synopsis
- Summaries

– Use of systematic reviews to formulate usable recommendations for patient care

❖ Includes formulation of strategies and tactics to ensure consistent use of proven medical practices

• Elizabeth Genovese MD/ACOEM 2004

Why Do We Need It ?

- ❖ Reduce variations in clinical practice
 - Medical care / tests and treatments
 - Determinations vis a vis work relatedness
 - Activity modification; time off work
- ❖ Set standards for overall quality of care
 - Foster utilization of effective rather than ineffective or harmful interventions
 - Maximize benefit; minimize risk (& cost)
 - Roughly assess cost vs benefit

Elizabeth Genovese MD/ACOEM 2004

Why Do We Need It ?

- ❖ Goal is, when possible, to use EBM as the foundation for CPGs
 - All CPGs are NOT evidence-based
 - Can be data driven or consensus based
- ❖ Sometimes the quality of the evidence is not adequate (can not guide CDM)
 - When this is the case, the default position is to use the best available evidence

Elizabeth Genovese MD/ACOEM 2004



Door Prize ! ! !

**5th Fastest Responder with the
Correct Answer Wins**

2 Adult Admission Tickets
(Valued at \$20.00)

Donated By:

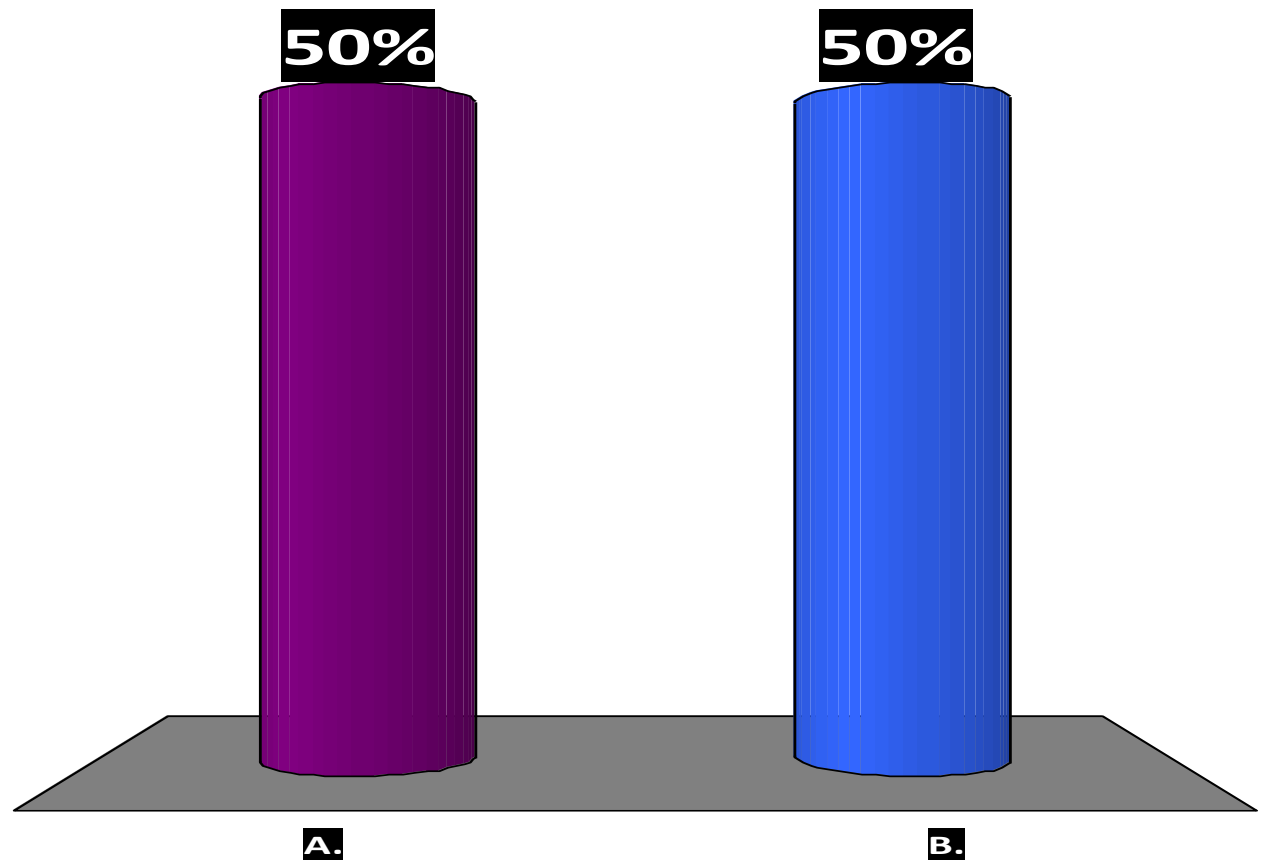


A C-20 (First Report of Injury) is not required for work-related deaths, but only for personal injuries?

A. True




B. False





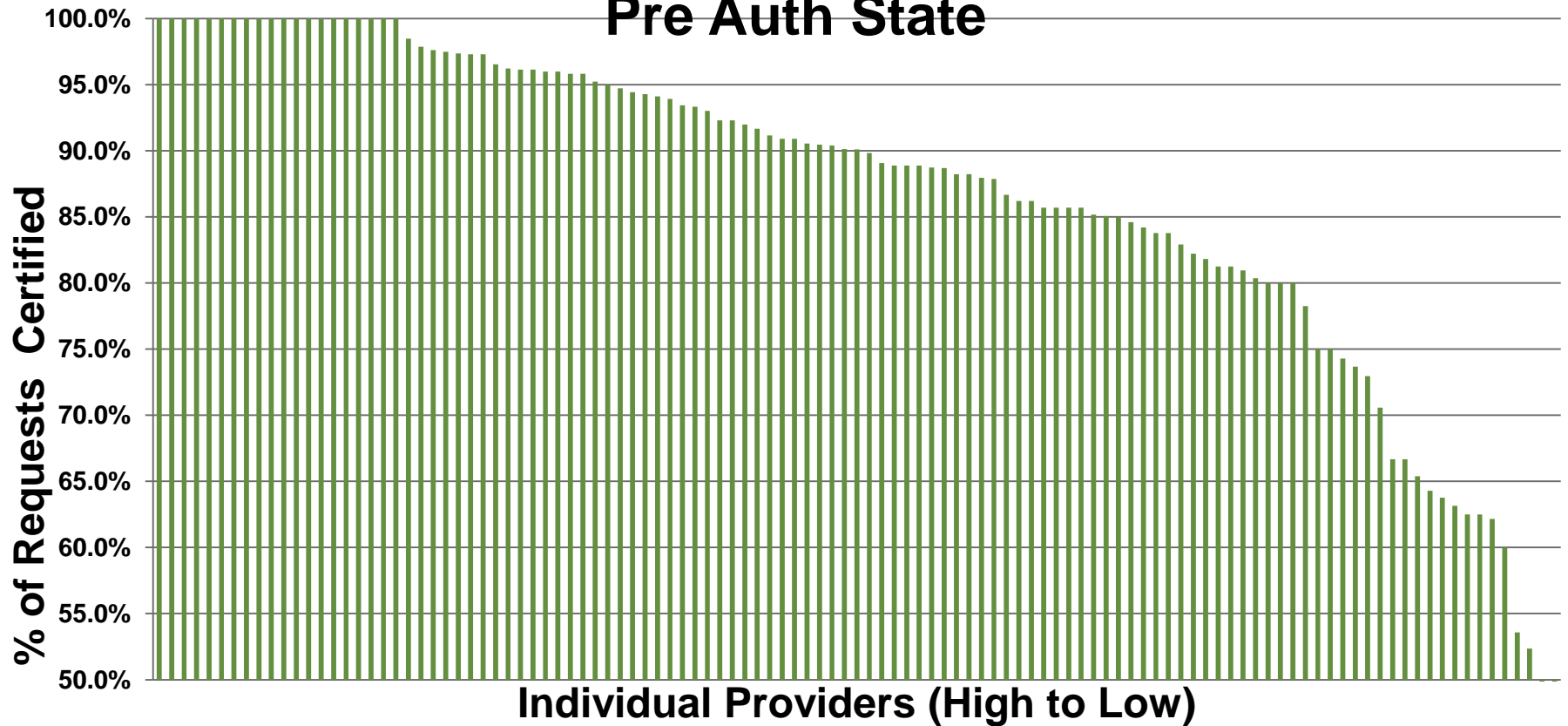
Fastest Responders

Seconds	Participant
0.741	7
0.855	13
1.245	4
1.286	2
1.445	18
1.479	28
1.494	14
2.53	30



Most UM requests are approved....

Certification from a high volume, mandatory Pre Auth State





Door Prize ! ! !



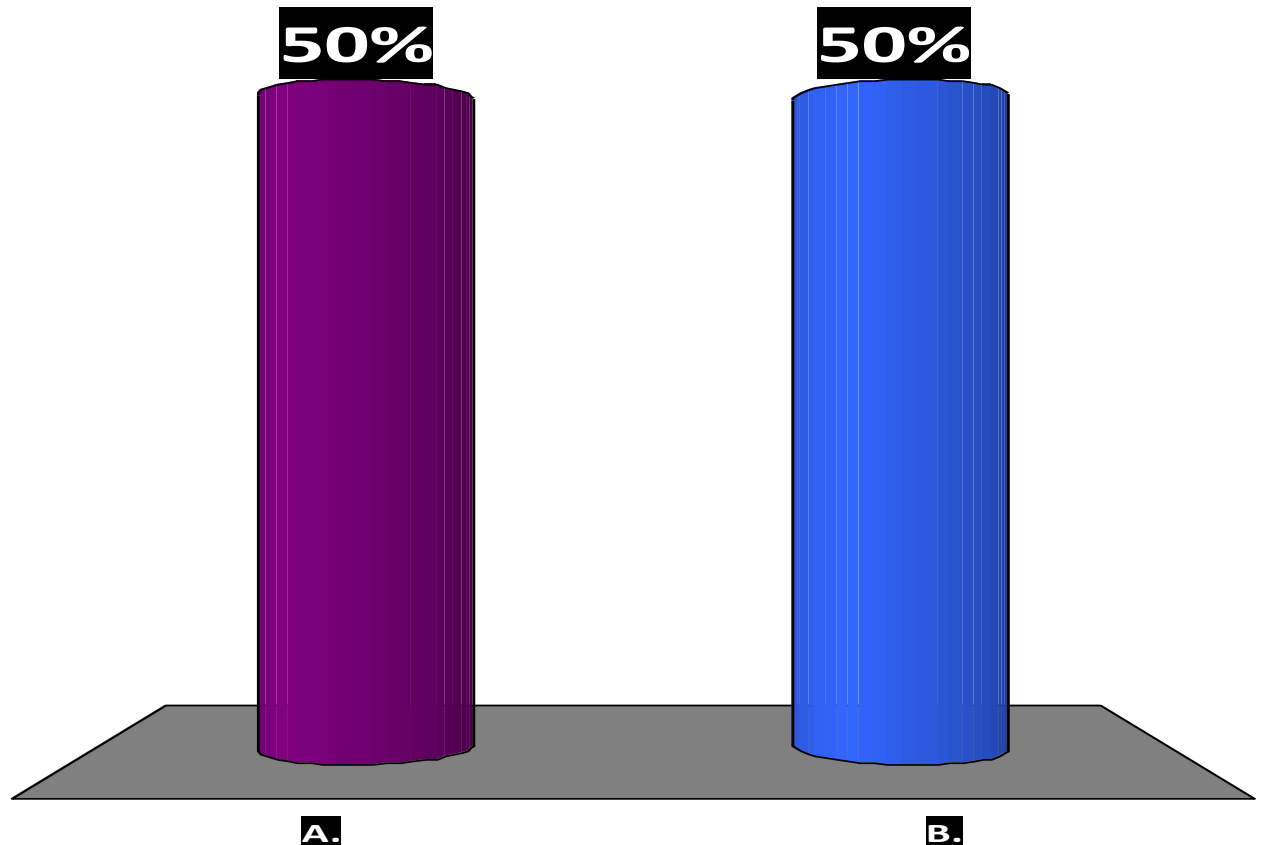
**7th Fastest Responder with the
Correct Answer Wins**

Two One Day Admission Tickets
(Valued at \$112.00)



If the carrier's utilization review agent denies a recommended medical treatment, does the statute grant the adjuster the ability to approve it anyway?


- ✓ **A. Yes**
B. No





Fastest Responders

Seconds	Participant
1.246	10
1.773	28
3.266	26
3.389	19
3.443	11
3.797	25
4.089	12
4.209	17
4.694	9
4.801	7



Utilization review is required per Tennessee regulations

- ❖ Tennessee Health Care Service Utilization Act 1992, ch 812 2 56-6-701 et seq & ch 0800-2-6.01-.13
- ❖ Utilization Review Administrative Rules include:
 - Utilization Review Process, including qualifications at the first, second and third (appeal) level of clinical review
 - Response time requirement
 - Notification requirements
 - Services requiring authorization / pre-certification



Liberty Managed Care's Utilization Review department is
URAC accredited & certified to conduct UM review in TN

URAC

❖ URAC

- A nonprofit, independent accreditation agency, providing a nationally and internationally recognized accreditation process and seal of approval
- Mission
 - To promote continuous improvement in the quality and efficiency of healthcare management through processes of accreditation and education

❖ Accreditation

- Liberty Mutual Managed Care (LMMC) is URAC accredited in Workers Compensation Utilization Management (WCUM)
- Receiving the accreditation certificate signifies a job well done and distinguishes companies as having met a standard of excellence.
- Many States and Federal agencies equate accreditation as activities to improve health outcome
- LMMC partners with other companies who are URAC accredited in WCUM

Utilization Review at Liberty Mutual

❖ Professional, clinical staff

- Main office - Wausau, WI
- Our UR staff is comprised of 50 registered nurses who have at least 3-5 years of clinical experience and average 5 years experience performing WC utilization review

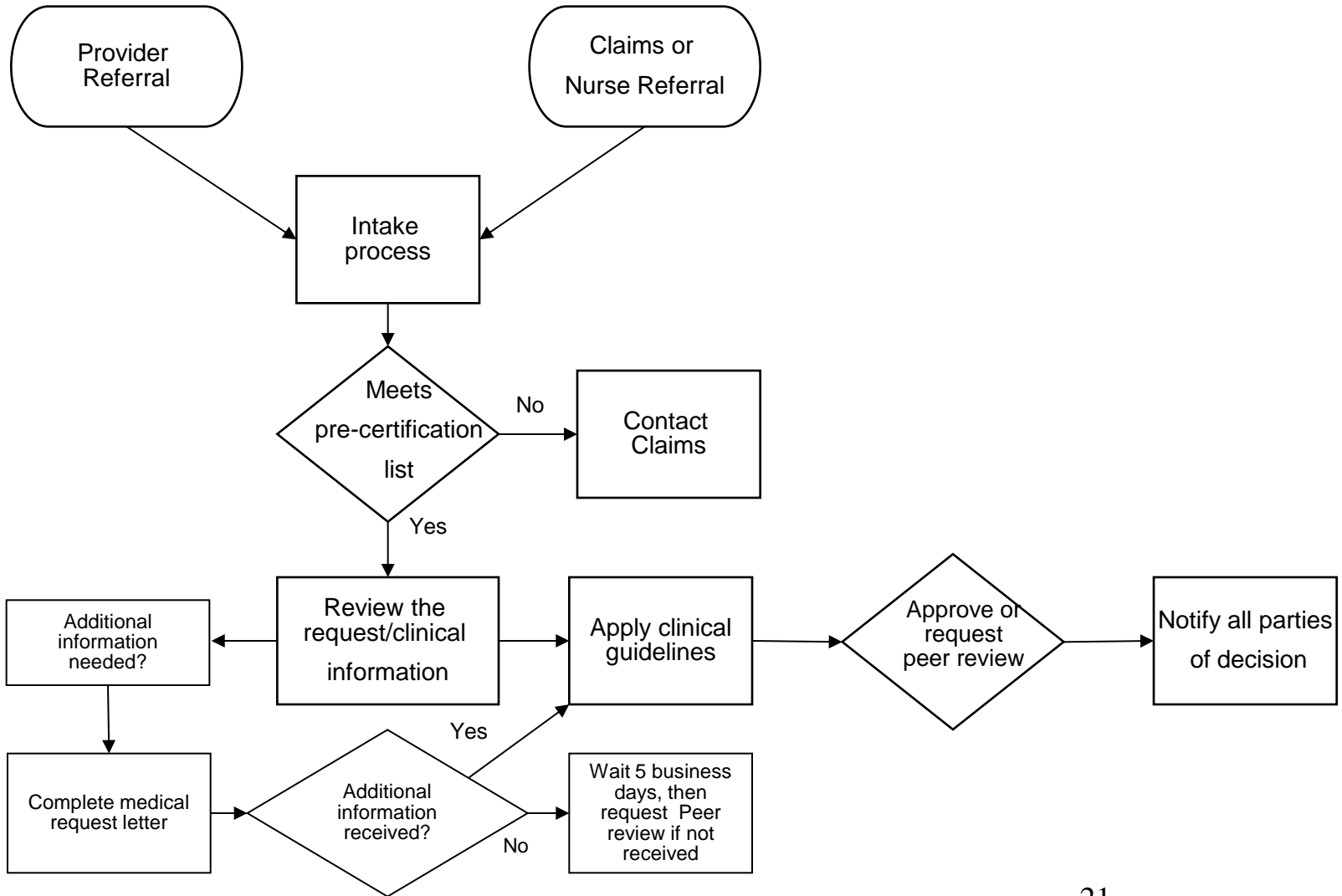
❖ Formal, disciplined UR process

- Access nationally accepted clinical protocols on medical appropriateness
- Utilize national peer review vendors who are managed by an internal product team and undergo a rigorous QA process performed by internal Regional Medical Directors each month
- Peer review vendors are URAC accredited

❖ Long accreditation and certification history

- Accredited by URAC since 1996
- Accredited or certified to perform UR where it is mandated or allowed by regulation

Utilization Review Workflow



UM Treatment for Review

- ❖ Inpatient Hospitalization
- ❖ Outpatient Surgery / Procedures, including:
 - IDET & Nucleoplasty
 - Injections, Epidurals, Acupuncture
 - Morphine Pumps
 - Spinal Cord Stimulators
- ❖ Chiropractic Treatment*
 - * Up to six (6) chiropractic treatment visits per back injury if chiropractor is the primary treating physician. No threshold on chiropractic treatment review when a discipline other than chiropractic is the primary treating physician
- ❖ Physical Therapy
- ❖ Occupational Therapy
 - Note: includes alternative medicine, massage, biofeedback
- ❖ Psychological services after fifteen (15) sessions / visits
- ❖ Multi-disciplinary Work Hardening or Work Conditioning Programs
- ❖ Investigational or experimental procedures
- ❖ Medications: Schedule II, III, IV use > 90 days as requested
- ❖ Treatment for which the claims department has questions regarding reasonableness, appropriateness, or medical necessity.

TN State Appeal Processing

- ❖ TN DOL staff communicates with the UM Department regarding a State Appeal request
- ❖ UM support staff communicate with CCM and gather records as requested by the DOL for the appeal
- ❖ Pain Management Appeals are handled by Eckman, Freeman & Associates
- ❖ UM support staff communicate with CCM and Eckman, Freeman and Associates, CCM and gather records as requested for the appeal

Liberty Mutual Utilization Review Audit Process

- ❖ Random, statistically significant selection of cases occurs monthly
- ❖ Review completed by Regional Medical Directors (RMD)
- ❖ Calibrate RMD impressions monthly:
 - they review the same file and we discuss the findings to maximize consistency
- ❖ Results shared with UM Peer Review vendor monthly including:
 - Quality of the file reviews
 - Turnaround Time (TAT)
 - Vendor Incident frequency and type

Utilization Review Audit Approach (continued)

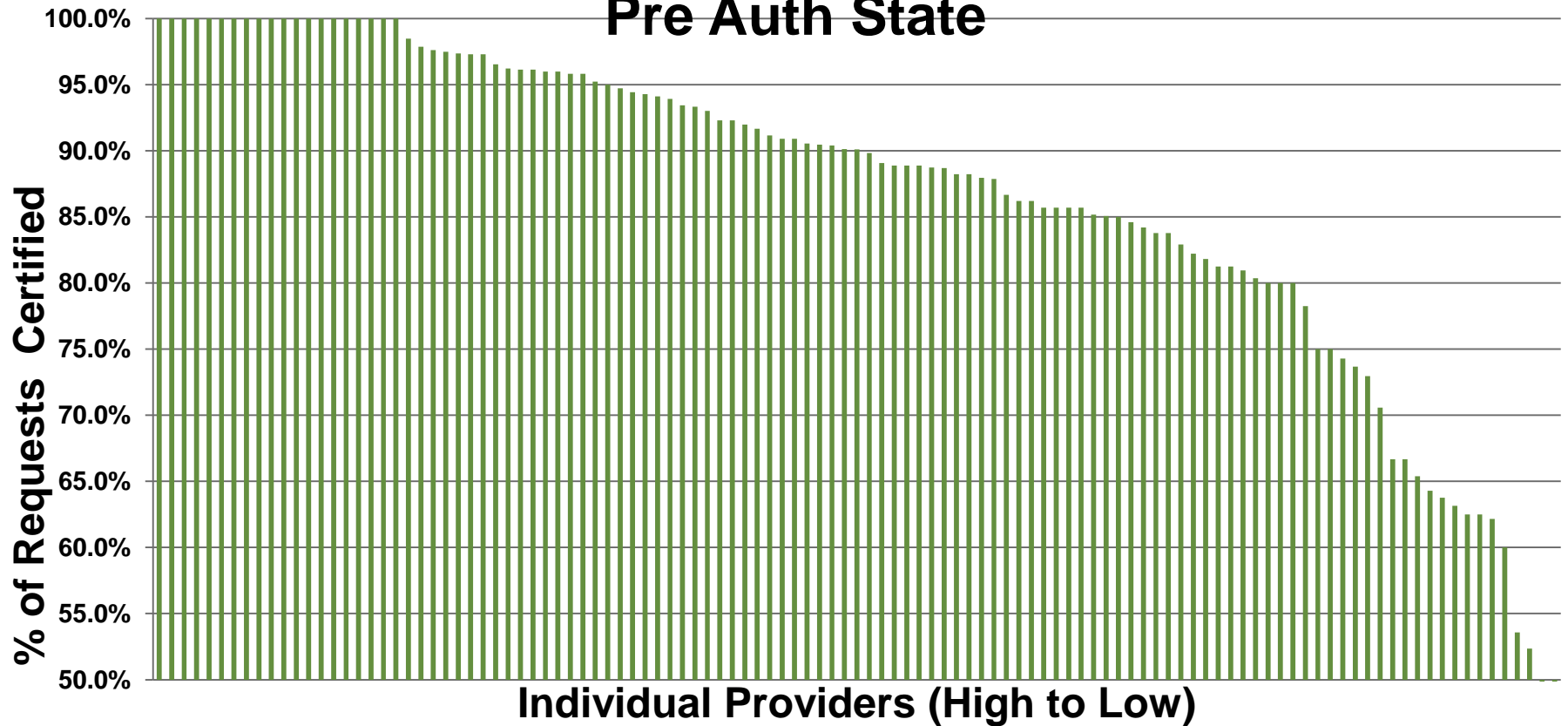
- ❖ Adjust referral volume based upon audit results
- ❖ Conduct semi-annual meetings with all UM Peer Review vendors and their Operational staff, QA staff and Medical Directors to discuss:
 - Quality
 - TAT
 - Vendor Incidents
 - Regulatory changes

Utilization Review Vendor Audits: 2013 1st Quarter Results

Vendor	< Average Clinical Quality	Turn Around Time Met	% of Internal Complaints per Referrals
UM Vendor 1	0%	96%	.7%
UM Vendor 2	15%	93%	.8%
UM Vendor 3	4%	97%	.2%
UM Vendor 4	5%	98%	.5%
Cross-vendor	5%		.5%

Most UM requests are approved....

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How to improve UM process and outcomes...

- Submit medical records that contain objective exam and other clinically pertinent information that support the request
- Support staff trained to submit the pertinent medical information and correct procedure codes
- Provide a clear contact number and if possible a time and be willing to discuss the request
- If the submitted documentation speaks for itself and supports the request then a discussion with the Pre Authorization doctor is often not needed
- Exceptions to guidelines require evidence

Thank you for your attention.....Questions?





Liberty Mutual[®]

INSURANCE



Utilization Review

Roxanne Brown
regulatory compliance manager



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Tennessee utilization review rules evolve



**2005 mandatory
utilization review
implemented**



**2011 notice of
appeal rights**



**2012 pharmacy
criteria added**



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UR brings medical quality focus to authorizations

Medical necessity

Setting considerations

Frequency and duration



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Claims examiners assist with creating best practices

Quality, timely care

Injured worker
awareness

Alternative treatment
planning, as needed

Coordination of care

Physician
understanding

UR decisions linked
to bill pay



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Thank you!



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